

## ***Workshop 6: Provider Training: Challenges in Implementation and Evaluation***

Moderators: Sherry Orloff and Mary Kay Larson

### **New York State Task Force for the Prevention of Perinatal HIV Transmission: Prenatal Care Provider Training**

Roberta Glaros, AIDS Institute, New York State Department of Health

David Odegaard, Downstate Medical Center, State University of New York

The objective of New York State's Prenatal Care Provider Training program (PRECARE) is to increase the prenatal HIV test acceptance rate to at least 90% (current New York State average) in facilities with lower rates. Activities to meet this objective include the selection of a training organization (in this case the Downstate Medical Center of the State University of New York at Brooklyn), identification of target facilities, and provision of technical assistance and educational programs to the prenatal care providers at selected facilities.

About 20 target facilities will be identified, based on these criteria: a) high seroprevalence areas (found chiefly in New York City); b) low rates of HIV testing; and c) high rates of expedited testing (offered at labor and delivery if women has not been tested during prenatal care and, if not done, required for the newborn).

To identify low rates of prenatal testing (<90%) and high rates of expedited testing, we will examine the maternal-newborn HIV test history data submitted (by law) by all birth facilities. These data indicate what the mother's HIV test history was at the time she presented for delivery and whether expedited HIV testing was done (on mother or newborn). From these data we will also be able to see over time any increases in prenatal testing and decreases in expedited testing at the target facilities.

David Odegaard of the Downstate Medical Center then discussed the obstacles and strategies in working with prenatal care providers under this program to improve HIV counseling and testing (C&T). Twenty-three hospitals in New York have been targeted for training; so far the Downstate Medical Center has been involved with 15 of these.

Barriers to training include:

- indifference ( "HIV not our problem," "we are doing a good enough job on this")

- competing priorities ( JACHO/other reviews, mergers, staff changes, overwhelmed by other health care issues)
- organizational/systems problems ( miscommunication, conflicting versions of who is responsible for HIV C&T, inefficient/inadequate C&T procedures, private MDs or other health care facilities as the source focus of inadequate C&T).

We have developed multiple strategies to overcome these barriers. A letter from the Director of the New York State Department of Health AIDS Institute to the hospital CEO (with copies to OB chair, OB administrator, HIV program director, etc.) provides the initial contact with the hospital. Included in the letter are statistics on the hospital's current performance, indicating that this performance does not meet state goals.

We contact the site and offer training, emphasizing the OB Grand Rounds lecture for clinicians, "Update on Guidelines for the Reduction of Perinatal HIV Transmission," presented by an MD and credentialed for CME. This lecture also stresses that HIV C&T a) is cost effective, b) is standard of care, c) can lead to liability issues if not properly conducted, and d) is increased when physicians and midwives encourage it among their patients.

With the OB chair (or, more likely, OB nurse or administrator) we complete an in-depth needs assessment to analyze the hospital's current system of prenatal HIV C&T, including who conducts C&T, how frequently, how patients are referred, and how C&T documentation is sent to Labor and Delivery wards. Through statistics provided by the state, we do further analysis to identify where the problem is.

We then arrange a meeting with OB representatives to review findings, which are summarized in a letter that identifies the problem areas and proposed solutions, such as training additional personnel to conduct C&T, steps to improve the documentation system, steps to make C&T a more efficient procedure, or technical assistance.

We offer tailor-made HIV C&T provider training to target site personnel as needed in various settings. Training includes techniques for streamlining C&T, role playing, documentation requirements, etc.

When we have completed all interventions we have a final meeting and/or summarize our training and technical assistance in a letter. We give the site contact a technical assistance packet, which includes guidelines, required state forms, quality assurance checklists, etc.

Finally, we monitor the site for 6 months to review HIV C&T rates. If statistics indicate there has been no change or a further decline in testing rates, we return to the site for further assessment and intervention.

Five hundred fifty prenatal care providers (MDs, nurses, midwives, C&T staff) have been trained thus

far. But the project has also done much to identify problems in the entire perinatal HIV prevention system.

### **Discussion Summary**

In response to a question about language barriers in the counseling setting, Mr. Odegaard commented that there was a need in New York to have HIV information translated into other languages. Members of the audience shared their state's experience using peer counselors and translators. In New York the most effective counselors focus on the effectiveness of the treatment, the fact that the child will be tested anyway, and the benefits to the child.

## **Perinatal HIV Prevention in Illinois: Assessment, Training, and Evaluation**

Christopher Mitchell, Midwest AIDS Education & Training Center

This project of the Midwest AIDS Education & Training Center and the Illinois Department of Public Health has as its objectives to:

- assess current practices related to HIV testing and counseling of pregnant women and the clinical management of HIV-positive pregnant women throughout the state of Illinois
- develop training and educational opportunities for perinatal providers based on the identified needs
- evaluate changes in practice patterns after perinatal prevention training
- compare providers' self-reported prevention practices with recalled experience of postpartum women.

Four perinatal networks "downstate" (outside of Chicago) and six within metropolitan Chicago constitute the perinatal network administrative structure in Illinois. To assess needs we conducted phone interviews with key informants (perinatal network administrators) from the four downstate perinatal networks and administered a self-report survey to perinatal providers within metropolitan Chicago.

An earlier attempt to survey providers by mail in the downstate area had produced a poor response rate (21% after 2 mailings). So we asked perinatal network administrators from the four downstate networks to survey obstetricians who have rights at their facilities while many of these providers were attending a local meeting. A 60%-70% response rate was achieved. There were consistent findings across the four networks.

The provider survey in metropolitan Chicago was administered by hospital personnel to a sample of 491

providers. Data was collected through provider self-report. Findings were remarkably consistent.

Based on the needs assessments, training and technical assistance opportunities were developed. Six months later a provider self-report survey was re-administered to training participants to evaluate changes in providers' practices (only 60 have been received so far). We are also developing a postpartum survey to be used with all women at all hospitals for a 1-month period. It will ask their recollections of prenatal HIV testing and counseling. We will then compare these findings with the providers' self-report of HIV prevention-related activities. We will again be working through the perinatal networks.

We believe the success of our efforts has been due to several factors: Working within the perinatal network structure, we have made this a collaborative effort to ensure "buy-in." We solicited the network's administrators input in form development and data collection strategies. We offered the networks a modest financial incentive. We obtained official letters of endorsement for the project, e.g., from the Director of Family Health. Finally, we reported findings in an easily understandable language.

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## **Provider Training in South Carolina**

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Ryan White Title IV is administered statewide in South Carolina; this gives us an advantage with respect to disseminating treatment guidelines and providing training to prenatal care providers. We also continue to conduct (with state funds) the Survey of Childbearing Women. Still, our HIV/AIDS surveillance system indicates that 80-100 infants born each year in South Carolina are exposed to HIV.

Key indicators of the need for provider training in South Carolina are:

- percentage (75%-95%) of pregnant women tested for HIV (PRAMS, provider survey)
- percentage (95%-99%) of HIV-infected pregnant women tested before birth (enhanced perinatal surveillance)

- percentage (54%) of hospitals offering rapid testing during labor and delivery
- percentage (around 80%) prescribed all three arms of antiretroviral therapy for perinatal HIV prevention (85% in prenatal period, 92% at labor and delivery, 98% neonatal).

The South Carolina AIDS Training Network, Ryan White Title IV clinicians, and MCH Regional Systems Developers have all been involved in perinatal HIV prevention training. The last group supports outreach educators to hospitals, prenatal care providers, and pediatric providers.

The goals of our project were to: a) target the 8 counties with the highest HIV prevalence rates, b) increase awareness of the current care system and available resources, c) maintain ongoing clinical training, d) address “gaps” and missed opportunities, and e) expand the type of prenatal care providers that are trained.

Our key strategies are:

- to contract with the South Carolina School of Public Health (Training Network) to produce a resource manual for more than 3600 providers statewide
- conduct 8 hospital trainings/physician trainings in 2001
- set up mini-residencies where high-level clinicians can provide an overview of perinatal prevention strategies
- conduct regional training for labor and delivery nurses and obstetrical staff in rural settings.

Through pediatric task forces, obstetrics task force, the statewide STD/HIV conference, web page linkages, and exhibits at professional meetings, we will promote general awareness and successes of perinatal HIV prevention.

Evaluation of the project will be through process measures (number of people participating), a 6-week post-training survey to assess changes in provider practice, and a survey of practices by providers and hospitals. We will monitor outcomes of the project through enhanced perinatal surveillance data and PRAMS data to identify specific gaps.

The challenges we continue to face are getting physicians to participate in the training, updating our resources and training with constantly changing information, and staff turnover.